

# 2009-2010 PRESCRIPTION MEDICATION PERMISSION FORM

I hereby certify that it is necessary for \_\_\_\_\_  
(Full Name of Student)

Grade level \_\_\_\_\_ Homeroom teacher \_\_\_\_\_  
to be given the prescription medication listed below during the school day, including when he/she is away from school property on official school business. Without this medication he/she will not be able to attend school.

Name of Medication: \_\_\_\_\_

Amount of liquid or number of pills brought to school: \_\_\_\_\_

Dosage to be given: \_\_\_\_\_

Route of administration (by mouth, eye drops, eardrops, injection, etc.) \_\_\_\_\_

Time of administration: \_\_\_\_\_ Beginning Date: \_\_\_\_\_

Ending Date: \_\_\_\_\_

Side effects: \_\_\_\_\_

Special instructions: \_\_\_\_\_

## Emergency Telephone Numbers:

Parent/Guardian: Name \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

Parent/Guardian: Name \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Telephone # \_\_\_\_\_

Parents are requested to pick up any leftover medication within one week after the ending date. Medicine left after this time will be discarded.

It is understood by the undersigned that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

- **Please note that FSUS students are not authorized to carry their own prescription medications without written preauthorization from the physician, which must be attached to this form.**
- **Please note that FSUS will not be responsible for assisting in the administration of non-prescription medication unless preauthorized in writing by a physician, which must be attached to this form.**